WISCONSIN STATE ASSEMBLY

22ND ASSEMBLY DISTRICT

SANDY PASCH

STATE REPRESENTATIVE

Assembly Bill 760
Testimony of Representative Sandy Pasch
Assembly Committee on Health and Healthcare Reform
March 3, 2010

Good morning, Mr. Chairman and fellow committee members. As the lead Assembly author of Assembly Bill 760, I thank you for allowing me to testify in favor of this legislation in front of you today.

Providing anesthesia is commonly understood to mean administering medication to place a patient in a state of controlled unconsciousness—otherwise known as general anesthesia—so that the patient does not feel pain during surgery. However, anesthesia also includes administering regional anesthetics, where only a portion of the body is made numb, as well as administering medications to sedate a patient to relieve pain or anxiety. During the administration of all forms of anesthesia, qualified anesthesia providers must monitor and maintain patients' critical life functions, and be both prepared and qualified to handle medical emergencies, or complications or side-effects related to anesthesia.

Anesthesia is used in hospitals and hospital-related facilities, dental offices and non-hospital ambulatory surgical centers/ambulatory surgical facilities (ASCs or ASFs). Through licensure and other regulatory efforts, Wisconsin currently oversees the provision of anesthesia in hospitals and hospital-related facilities and dental offices. But there is no regulatory oversight of the use of anesthesia in ASCs or ASFs.

Periodically, the media reports tragic stories from other states in which patients undergoing procedures in ambulatory outpatient facilities suffer grievous and permanent injuries or die from complications or side-effects of anesthesia administered by unqualified personnel. Though no such catastrophic events have been reported at unregulated facilities here, the problem has reached Wisconsin nonetheless. As you will hear in subsequent testimony, the Ayer family of Waukesha lost their daughter to a case of over-sedation during an office-based plastic surgery procedure in Florida.

Assembly Bill 760, which Mr. Ayer is here to testify in support of today, is designed to provide regulation through licensure of ambulatory surgical facilities. These are defined as places where major regional anesthesia, general anesthesia, or moderate or deep sedation, is produced in humans. To qualify for a license under this legislation, facilities must be approved by Medicare or accredited by a national accrediting body. This proposal would provide Wisconsin its first regulatory oversight of anesthesia administered in the ambulatory facilities, and help ensure the safety of Wisconsin patients.

This bill has the support of the Wisconsin Society of Anesthesiologists, the Wisconsin Society of Plastic Surgeons, and the Wisconsin Medical Society.

Once again, thank you for allowing me to testify in favor of this important legislation.

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THE WISCONSIN SOCIETY OF ANESTHESIOLOGISTS, INCORPORATED

TO: **Representative Jon Richards, Chair**
Members, Assembly Committee on Health and Healthcare Reform

FROM: **Jay Mesrobian, MD, Immediate Past President**

DATE: **March 3, 2010**

RE: **Support for Assembly Bill 760 – Licensure of Ambulatory Surgery Facilities**

On behalf of Wisconsin's Anesthesiologists, I ask your support for Assembly Bill 760 which would provide Wisconsin's first-ever regulation of how anesthesia is provided in Wisconsin's Ambulatory Surgery Facilities. (You will hear many acronyms and anesthesia-related terms today, so attached to this memo are a variety of definitions to assist the translation.)

"Providing anesthesia" is generally thought of as the administration of medications (inhaled or intravenously) to surgical patients that render the patient unconscious and unable to feel pain associated with surgery (commonly referred to as "general anesthesia"). Anesthesia can also be used to numb large or small areas of the body, or to sedate a patient for minor surgical procedures.

Anesthesia medications can cause unpredictable side-effects; some are minor, some can be life-threatening. Patients can also have other underlying health conditions that are exacerbated by anesthesia, or by surgery itself. Among the most critical responsibilities of a qualified anesthesia provider (Anesthesiologists, Anesthesiologist Assistants or Certified Registered Nurse Anesthetists) is to monitor a patient's vital life functions and be prepared to immediately treat anesthesia-related side-effects or other complications. Improperly administered anesthesia, or the failure to properly treat unexpected side-effects or other complications can lead to permanent injuries, coma and death.

Commonly, anesthesia is thought of as something that happens in a hospital operating room. But anesthesia is also used in dental and oral surgery facilities, as well as non-hospital outpatient surgery centers, often referred to as Ambulatory Surgery Centers/Facilities (ASCs/ASFs). Among the most commonly recognized type of outpatient surgical procedures are various cosmetic (or plastic) surgery procedures, but many other surgical procedures occur at outpatient surgery centers.

In Wisconsin, the provision of anesthesia in hospitals, hospital-related surgery centers and dental/oral surgical facilities is closely regulated. ***However, there is no state oversight or regulation of how anesthesia is provided in non-hospital outpatient surgery centers – we are one of only seven such states nationwide***. AB 760 would provide Wisconsin's first-ever oversight of anesthesia in such facilities. An ASF would qualify for the state license if they are an approved ambulatory surgical center by Medicare, or are accredited by a national accrediting body – meaning this does not recreate the wheel, rather would simply adopt very well established guidelines and does not create redundant regulation of hospitals or hospital-based facilities, or dental/oral surgery facilities.

Please join us in supporting this important patient-safety legislation.

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DEFINITIONS

Minimal Sedation Anxiolysis: a drug-induced state during which patients respond normally to verbal commands. Although cognitive and physical coordination may be impaired, airway reflexes, and ventilatory and cardiovascular functions are unaffected.

Moderate Sedation/Analgesia: a drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.

Deep Sedation/Analgesia: a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.

General Anesthesia: a drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.

Because sedation is a continuum, it is not always possible to predict how an individual patient will respond. Hence, practitioners intending to produce a given level of sedation should be able to rescue patients whose level of sedation becomes deeper than intended. Individuals administering Moderate Sedation/Analgesia should be able to rescue patients who enter a state of Deep Sedation/Analgesia, while those administering Deep Sedation/Analgesia should be able to rescue patients who enter a state of General Anesthesia.

DEFINITIONS (CONTINUED)

Licensure: an authorization that allows the operational activities of a facility such as an ambulatory surgery center or hospital.

Certification: the procedure or action by which the Centers for Medicare and Medicaid Services (CMS) evaluates and recognizes an institution that has met all requirements or conditions for participation in the Medicare program. Certification is required of any center that wishes to bill Medicare or Medicaid for patient services

Accreditation: a voluntary process undertaken by an institution to demonstrate it meets or exceeds certain national criteria. The process of accreditation involves a self-assessment by the facility, followed by an on-site review by the accrediting body.

ORGANIZATIONS

ASF: Ambulatory Surgical Facility. Defined as any place, other than a hospital, at which anesthetic agent is administered to humans to produce major regional anesthesia, moderate sedation, deep sedation. or general anesthesia.

CMS: The Centers for Medicare and Medicaid Services

JCAHO: The Joint Commission for Accreditation of Healthcare Organizations

AAAASF: The American Association for Accreditation of Ambulatory Surgical Facilities

AAAHC: The Accreditation Association for Ambulatory Health Care

WSPS WISCONSIN SOCIETY OF PLASTIC SURGEONS

To: **Members, Wisconsin State Legislature**

From: **The Wisconsin Society of Plastic Surgeons**

Date: **March 3, 2010**

Re: **Support for Assembly Bill 760 – Regulation of Anesthesia in Non-Hospital, Outpatient Surgery Centers**

The Wisconsin Society of Plastic Surgeons strongly supports the passage of Representative Pasch's legislation to regulate anesthesia in the non-hospital, outpatient setting. Plastic surgeons commonly perform procedures requiring anesthesia in the outpatient setting. We view the licensure of outpatient surgery centers as a cornerstone in providing a safe environment for our patients undergoing these procedures.

Over the last several years reports of harm to patients undergoing plastic surgery in unregulated facilities has resulted in an emphasis within our national as well as state societies on ensuring patient safety. The American Society of Plastic Surgeons (ASPS) represents about 94% of practicing plastic surgeons in the country. As part of its culture of patient safety, the ASPS currently mandates licensure for all surgical facilities in which its members practice. Additionally, the ASPS has advocated for the enactment of legislation regulating outpatient surgical facilities with many states adopting legislation similar to Assembly Bill 760.

Oversight of facilities in which complex medical procedures are being performed begins with appropriate accreditation and enhances patient safety. Thank you for your attention to this important matter

Respectfully submitted on behalf of the Wisconsin Society of Plastic Surgeons,

Christopher J. Hussussian, MD, Treasurer

Donald W & Maureen Ayer
1455 Hillside Dr.
Waukesha, Wis. 53186
262 366 9503

Date: March 3, 2010

The Honorable Sandy Pasch and
The Wisconsin Assembly Health Committee Hearing
Room 417 North, State Capitol Building
Madison, Wis.

Our family extends our appreciation to Rep. Pasch and to the Wisconsin Society of Anesthesiologists for being invited to speak at this hearing. Ever since we learned what happened in the story I am about to relate, it has been our hope that one day we would use this story to help push a strong patient safety bill, somewhere in the nation, into law. But we never dreamed that state would be right here in Wisconsin.

What I am about to describe was the subject of a firestorm of news coverage in the Milwaukee market, western Florida and on ABC 20/20 in 2004.

On Sept. 25, 2003, I was in the local Menard's store when I received a phone call. My wife, Maureen said, "Don, you have to come home." I said why, what's going on? She said, "I can't talk about it over the phone, you have to come home now." I said why, what's going on? She said, "Julie went in for a breast implant this morning, and they can't wake her up."

We flew to Sarasota on the first flight, and were there in Sarasota until Dec. 7, 03, when we flew her via a Lear Jet air ambulance to

Waukesha. She died there on Dec. 26, 2003. Hypoxic encephalopathy (brain damage due to lack of oxygen), in a persistent vegetative state. We didn't know what occurred in that surgery room until Jan 3, 04, when the surgical tech blew the whistle to ABC in Tampa.

Her procedure was just another breast augmentation, just as they do every day, in every state in the nation. But that procedure turned into a series of disasters.

The **first disaster** was that the Cosmetic Surgery Center was a slick storefront for the doctor's office. It was not an accredited surgery center. Doctor's offices have a death rate 10 times higher than accredited Ambulatory Surgery Centers or Hospitals.

The **second disaster** was that the anesthesia was directed by the plastic surgeon, a doctor who had no certification in anesthesia, and the RN who administered the anesthesia had no certification either. In other words there was no anesthesiologist nor a Certified Nurse Anesthetist on the surgery team.

The current firestorm of news in this country is about a drug named Propofol given to Michael Jackson. The story is that the doctor there, also not an anesthesiologist, gave Jackson 50 mgs. of Propofol. The surgeon in Julie's procedure gave her a cocktail of drugs, which included a hit of **1500 mgs. of Propofol.**

Cardiac arrest, stopped breathing, dead on the table. The RN alerted the doctor; "There's something wrong." The surgical tech wanted approval to start chest compressions. Doctor told him to wait, not yet. A scramble to find a pulse.

The Worst Disaster: The doctor did not go to rescue protocol, a delay, continued the surgery, and a rush to find a pulse. No pulse.

Approximately three more minutes passed. Cursing and swearing by the doctor - panic. Surgical tech yelled, "Doctor, we have to start chest compressions, her finger tips are turning blue, her lips are blue!!"

Chest compressions approved, her heart rate went to a high rate, breathing normal. But it was too late. Brain damage and coma, death three months later in Waukesha, and she is interned in the Prairie Home Cemetery.

A similar disaster could happen here in Wisconsin because we are one of the states that does not require all surgery centers or doctor's offices be accredited. Dr. Hector Vila, Tampa, Fl. studied the anesthesia related death rate in Florida and found that those procedures done in a doctor's office were 12 time higher, not 12%, 12 times higher than in accredited facilities.

So who knows what the surgery related death rate is here in Wisconsin? Nobody. We suggest that your committee poll all members of the Wisconsin Coroners and Medical Examiners Association for a survey of surgery related deaths in the past five years to see if there is a difference between accredited vs non-accredited surgery facilities.

We're talking regulation here. We know that ever since 1980 it has been cool to ridicule regulation in this country. We also know that if this bill had been law in Florida back in 2003, Julie would be alive. We also know that if an anesthesiologist or a CNA had been on the surgery team, Julie would have been home for Christmas, rather than dying in a nursing home.

Sincerely,

Don & Maureen, Wade, Colleen Ayer Kopshinsky,
The Ayer Family

TO:	Members, Assembly Committee on Health and Healthcare Reform
FROM:	LoAnn Vande Leest, CEO, Surgery Center, LLC, Franklin, WI
DATE:	March 3, 2010
RE:	Assembly Bill 760, relating to ambulatory surgical facilities

Background Information Regarding Ambulatory Surgery Centers
The first ASCs were established in the United States in the early 1970s, with Medicare first offering coverage for ASC services under Part B in 1982. At that time there were only 30 surgical procedures that met government guidelines for coverage. Since the 1980s, the share of surgeries performed in outpatient settings has grown significantly. In 1981, approximately 81 percent of surgeries were performed in hospitals on an inpatient basis. By 1999, inpatient surgeries represented only 37 percent of all surgeries, compared to 63 percent for outpatient surgeries. These shares have remained stable for the past several years. (Documented in, An Analysis of Recent Growth of Ambulatory Surgery Centers, prepared by KNG Health Consulting for the ASC Coalition in June 2009).

In 2008, there were approximately 5,149 Medicare-certified ASCs in the United States. This number has increased steadily over the past ten years. The vast majority of ASCs remain under private ownership.

ASCs offer a variety of surgical services. National reports estimate that 35 percent of ASCs are multi-specialty providers that provide a mix of surgical services. Examples of some of the most common services provided by ASCs include:

- Gastrointestinal (24%)
- Ophthalmology (19%)
- Pain management (8%)
- Orthopedics (7%)
- Dermatology (4%)
- Urology (2%)
- Other (1%)

Association of Wisconsin Surgery Centers (WISCA)
The Association of Wisconsin Surgery Centers, Inc. (WISCA) was formed in 1989. Its purpose is to support the exchange of ideas among professionals engaged in the clinical and administrative management of ambulatory surgical centers and to serve as a mechanism whereby solutions to management problems and needs may be developed through concerted group efforts.

Since its inception, WISCA has helped develop important health policy in Wisconsin, including the statewide ASC reporting criteria, develop a fair and equitable plan to fund Wisconsin's Health Insurance Risk Sharing Pool (HIRSP) and work to address issues related to Workers' Compensation carrier operating in the state. WISCA continues to be committed to help make positive changes within our industry with the ultimate goal of improving the care and service provide to the healthcare consumers we serve.

There are an estimated 60 accredited surgery centers in Wisconsin. Over one-half were members of WISCA last year, with 75 percent estimated this year.

Assembly Bill 760
Thank you Chairman Richards, and Committee Members, for the opportunity to provide testimony to you today on Assembly Bill 760: relating to ambulatory surgical facilities.

We feel it is important to provide a representation of Wisconsin's Ambulatory Surgery Centers as well as to help provide an understanding of what they do, as well as how they are currently regulated.

My name is LoAnn Vande Leest. I am CEO of the Surgery Center, LLC, in Franklin, WI. It is a joint venture entity owned 50 percent by Aurora and 50 percent by independent physicians. It is one of the larger ASCs in the state and we do more than 7,000 cases a year in Wisconsin.

Surgery centers in Wisconsin and across the country have become an alternative for many patients who are looking for specialized, efficient, quality health care, care that is often at a lower cost than a hospital providing the same services. Thanks to improved technology, outpatient surgery has become more and more the option for patients requiring simple surgery.

Lower costs, shorter wait times for surgery, and a comfortable environment have resulted in a growing number of patients using surgery centers as well as a growing number of surgery centers in Wisconsin.

In addition to my facility there are ambulatory surgery centers in Wisconsin that specialize in all different kinds of care including: gastrointestinal, ophthalmology, pain management, orthopedics and urology.

While we view the proliferation of surgery centers as a positive outcome of improved care, lower costs and advancements in medical technology, we are also watching the proliferation of regulations in regard to surgery centers across the country.

A patient's safety should always come first, and we support the state taking measures to ensure patient safety. We applaud such measures and will always work with legislators who have concerns about the work done at ambulatory surgery centers. And while we support the concepts in AB 760, we do have some concerns. Wisconsin surgery centers undergo an extensive process for accreditation and have an exemplary record of patient safety in our state.

The tragedy portrayed in a letter circulated by the Wisconsin Anesthesiologists is heartbreaking and hopefully something that doesn't happen here or anywhere. But ultimately what took place was not at an ambulatory surgery center, and it occurred in a state that has a licensing requirement for surgery centers.

To many of the surgery center owners I have spoken with, AB 760, while well intended, adds another layer onto our already cumbersome and costly accreditation process.

Here is the process that my surgery center went through to receive national accreditation:

1) An initial self assessment of the facility, its governing body and all responsibilities and actions thereof, all policies and procedures, all practices of staff and physicians, Risk Management, Quality Control, Peer Review, Credentialing cycle information, and much

more. When it's a Medicare deemed survey, the microscope gets more magnified, and the degree of survey toughness is multiplied ten-fold.

2) An application of no less than 25 pieces of evidence is submitted to the accrediting body.

3) A fee of $12,245 (for our facility)

4) A two-day grueling survey

5) A wait of two weeks to find out what needs to be fixed, if anything, from a Medicare Condition for Coverage aspect.

6) Correction of those items

7) Another full application

8) Another $12,245 fee

9) Another two-day grueling survey

10) Another wait before Medicare/Medicaid patients can be seen

11) Reapplication/resurvey every three years

12) An incredible amount of work during the three years to maintain excellence and readiness for the next survey.

Maintaining accreditation for a surgery center is no easy task, and can be very costly. We understand that the bill seemingly only adds one simple step for Wisconsin licensure. But it's not that step which concerns most ASC owners, it is what may follow. For example, we just witnessed ASC licensing fees in Illinois rising from $300 to $1,500.

In addition to the thousands of dollars we pay in accreditation fees, we were included in the 2009-11 Budget's hospital assessment where, under the formula, more of our centers come out losers than winners. But unlike hospitals, surgery centers also pay taxes as for-profit entities.

The growing cost of doing business and additional requirements that may come once licensure is under the auspices of DHS remain our concern with AB 760. That said, in the short term WISCA members are also willing to work with the authors of the bill on potential amendments that would give our accredited members peace of mind, but also address the problem they are seeking to address.

Conclusion

Thank you for your time today, and if you have any questions about Wisconsin surgery centers or the process we go through for certification, I would be more than happy to try and answer them.

Children's Hospital and Health System™

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Children's Miracle Network®

TO: Chairman Richards & Members of Assembly Committee on Health & Health Care Reform

FROM: Michelle Mettner, Vice President Government Relations & Advocacy Children's Hospital & Health System

DATE: March 2, 2010

RE: AB760 Regulation of Surgical Ambulatory Facilities

Thank you for holding a hearing on AB760 relating to the regulation of ambulatory surgical facilities. Children's Hospital & Health System operates an ambulatory surgical center that is approved by the federal Department Health & Human Services and we support the creation of state regulations and standards on such centers. In fact, Wisconsin is one of few states that does not currently license and regulate ambulatory surgical facilities.

We are concerned with one aspect of the legislation. The bill mandates that surgical facilities report deaths "resulting" from complications due to anesthesia to the Medical Examining Board or Board of Nursing.

It's always difficult to know why a patient dies. There could be multiple contributing factors or factors that are unknown at the time of death or just after the time of death. The legislation forces a facility to make a definitive spot judgment of causation which may or not be accurate. We respect and support the intent of getting information reported on deaths that occur in this setting so that follow-up investigation may ensue. We suggest that a more appropriate approach is a requirement that all deaths that occur within 72 hours of discharge following a procedure be reported to the licensing agency for ambulatory surgical facilities. This would protect against under reporting (by those who cannot make the definitive causation claim as contemplated by the legislation) and against a facility making an inaccurate conclusion regarding causation when there could be multiple factors that should be investigated.

Thank you for your attention to our concerns. Please feel free to contact me with any additional questions.

Michelle I. Mettner
Vice President, Government Relations & Advocacy
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mmettner@chw.org

A botched surgery at an outpatient clinic

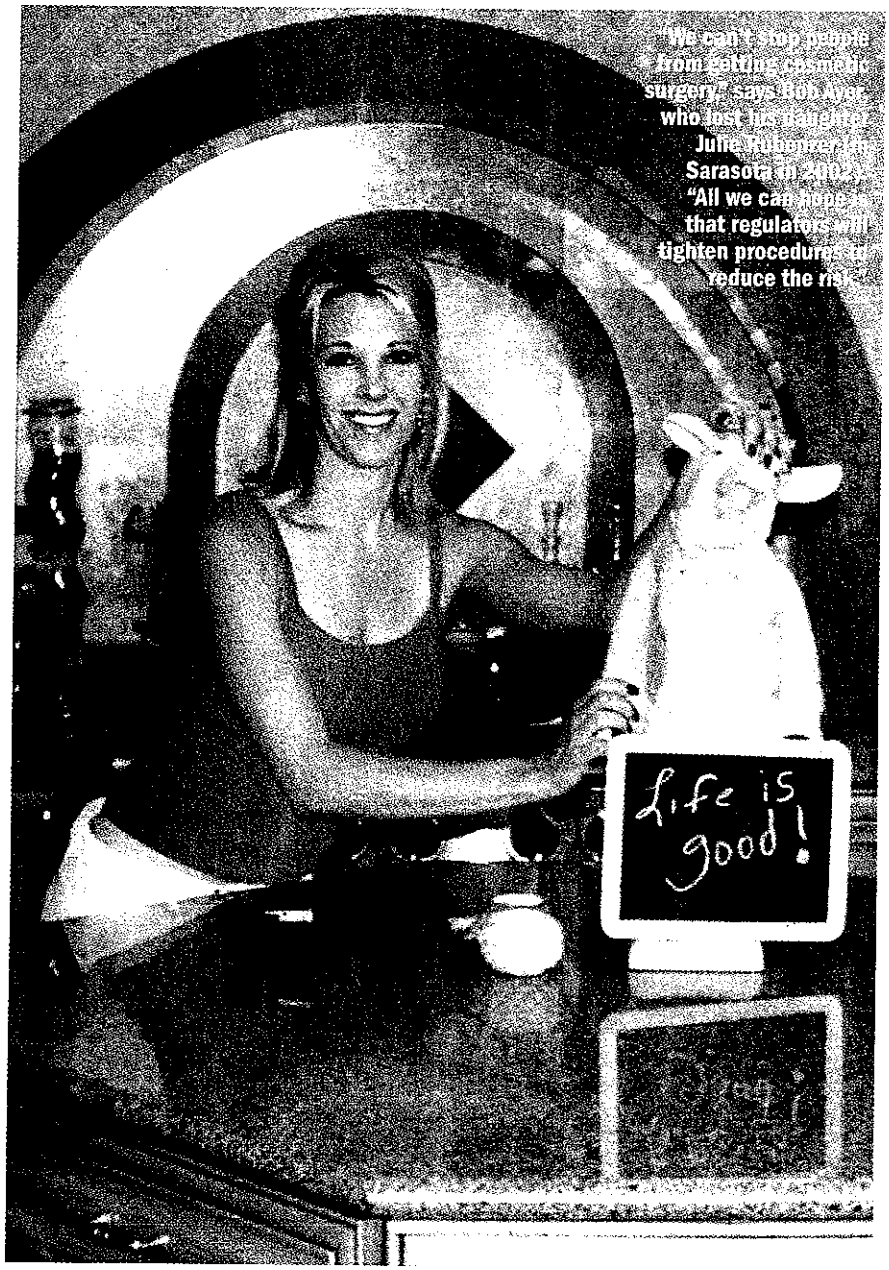
JULIE RUBENZER, 38
Breast implants

An upbeat saleswoman and marathon runner, Julie Rubenzer was no stranger to the knife: By 2003 she had had a rhinoplasty, two procedures to plump and reshape her breasts and collagen injections in her lips. The reason she chose Dr. Kurt S. Dangl to perform another breast augmentation, says ex-husband Bob Rubenzer: "Other doctors were turning her down. She was the perfect female specimen."

An M.D. who was once licensed as a dentist, Dangl performed implant surgery on Rubenzer at the Cosmetic Surgery Center at a strip mall in Sarasota. His record was not unblemished: The Florida Department of Health had logged a complaint against him for deceptive practices. According to an anesthesia expert consulted by a lawyer for Rubenzer's parents, Dangl acted as both surgeon and anesthetist that day—giving Julie "gross overmedication," in the words of the expert. A certified surgical technologist who asks to remain anonymous tells PEOPLE that he was present when Rubenzer's heart and breathing stopped as the surgery was ending; Dangl, he said, squeezed air into her lungs with an "ambu" bag but delayed attempts to restart her heart. "Julie's fingers were just blue," says the CST. "She was dead on the table."

Not quite: Her heart eventually was restarted and she was taken to Doctors Hospital, where she lingered in a coma for 10 weeks. On Dec. 7 her parents, Bob and Maureen Ayer, took her home to Wisconsin in an air ambulance. She spent her last days curled in a fetal position at a medical center in Brookfield, Wis. On Dec. 26, she died.

Back in Florida, Dangl has declined to comment on the case (which reportedly is under investigation by state health officials). Says Bob Rubenzer: "He's still practicing, with big ads in the Sarasota papers."



"We can't stop people from getting cosmetic surgery," says Bob Ayer, who lost his daughter Julie Rubenzer (left) in Sarasota in 2003. "All we can hope is that regulators will tighten procedures to reduce the risk."

COURTESY AYER FAMILY

What you need to know before surgery

Last year 8.3 million patients had cosmetic procedures in the U.S.—up 293 percent since '97. Some were performed by dentists or others "with no formal training in cosmetic surgery," says Dr. Robert W. Bernard, president of the American Society for Aesthetic Plastic Surgery. How to protect yourself:

- Choose a surgeon certified by the American Board of Plastic Surgery.
- Ask candidates about their safety records and consult your other physicians for recommendations.
- For an in-office face-lift or liposuction, ask whether the surgeon has privileges to do the procedure in the hospital that he's affiliated with. (If so, he'll have been vetted by the hospital's surgical committee.)

Wisconsin Association
Nurse Anesthetists

To: Chairperson Jon Richards and Members of the Assembly Health & Healthcare Reform Committee

From: Larry Beck, President of the Wisconsin Association of Nurse Anesthetists

Re: AB 760 – Ambulatory surgical facilities

Date: Tuesday, March 2, 2010

The nearly 700 members of the Wisconsin Association of Nurse Anesthetists statewide wish to compliment Representative Pasch and the other authors for introducing AB 760. The objective is laudable: to improve the quality of care received at ambulatory surgery centers.

We believe, though, that the legislation should be broader than AB 760 proposes. **All offices and facilities that offer surgical services and require anything more than local anesthesia or light sedation should be licensed according to Wisconsin DHS standards or other national accrediting organizations approved by the Wisconsin DHS.**

In addition, AB 760 requires reporting of deaths only if they are anesthesia-related. The reporting requirement should apply to deaths due to **any** complication, not only anesthesia-related. All healthcare providers should participate in the accountability that is sought.

Finally, health care consumers expect the same standard of care from a surgical center or doctor's office whether it is linked to a hospital or is an independent facility. The same quality standards should apply across-the-board and not vary depending on who owns or operates the location where surgery and anesthesia services are provided.

Thank you for your consideration of these views regarding AB 760. The legislation is a good proposal that should be made better.

Lawrence K. Beck, CRNA
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Ambulatory surgical centers may exceed performance of hospitals for certain procedures

Measuring five quality-base performance areas, an ambulatory surgical center out performed a standard hospital based surgical center in otolaryngic surgeries, according to new research in the December 2009 issue of *Otolaryngology - Head and Neck Surgery.*

The cross-sectional study analyzed a total 486 cases at a pediatric ambulatory surgical center (ASC) and a hospital-based facility (HBF). The cases comprised of the four most common pediatric surgical procedures at the ASC compared to the HBF: ventilation tube insertion, dental rehabilitation, adenotonsillectomy, and ventilation tube insertion/adenoidectomy. Only outpatient procedures were included.

The authors designed a series of quality performance measures based on the Institute of Medicine's multidimensional definition of quality. The study aimed to develop a better understanding of how an ASC might be a viable high-quality, low-cost organizational structure. The quality measures included: safety, patient-centeredness, timeliness, efficiency, and equitability.

Seventy-seven percent of ASC cases finished within the scheduled time compared to 38 percent at the HBF, a difference of about 30 percent. Total charges were 12 - 23 percent less at the ASC as well. However, patient satisfaction was similar between facilities (ASC, n=64; HBF, n=35). For the studied sample size, the ASC had no unexpected safety events, compared to nine events at the HBF.

The authors point out that as the healthcare industry responds to public demand for higher quality with scarce resources, innovative delivery models that provide high-quality, low-cost care are increasingly needed. ASCs have been described as such a model by taking advantage of economies of scale and low-cost organizational structures. The authors further note that although previous studies have shown the benefits of ASCs in one quality measure or another, this study is the first to explore multiple dimensions of quality in one surgical area to give a more complete picture.

The authors write "Intense competition, increasing quality standards and scarce resources have led many institutions to shift toward 'service-line' strategies, allowing facilities to concentrate on what they do best. It makes sense, at least, for institutions to determine what types of organizational structure provide the best patient care." The results of this study suggest that government programs supporting ASCs may be a wise use of resources and that investment in ASCs is a way academic health centers can remain financially competitive.

Source: American Academy of Otolaryngology -- Head and Neck Surgery